State of Connecticut
Department of Developmental Services

Check List for Application Process

Application packets received with <u>all</u> required documents listed on the following Checklist, can be processed upon receipt.

Name: _____ Town of Residence: _____ Date of Birth: _____

Step 1- Complete the Eligibility Application form.

☐ ***<u>Please remember to sign the Application form as only Applications that have been signed can be accepted.</u>***

Step 2- Include the following in your application packet:

☐ **All Psychological and Educational Testing:** This testing can usually be obtained from schools, agencies, or private psychologists upon your request.

- **Intelligence/Cognitive tests:** These tests, such as the Wechsler or Stanford-Binet, assess the applicant's intellectual/cognitive ability and generate IQ scores. Please submit all tests available. IQ scores are required for applicants over the age of 8.
- **Adaptive skills tests:** These tests, such as the Vineland or Behavior Assessment System for Children (BASC), evaluate the applicant's capability with daily activities such as dressing, grooming, and social skills. Please submit all tests available.
- **Autism diagnostic testing (if applicable):** These tests, such as the Gilliam Autism Rating Scale (GARS), Childhood Autism Rating Scale (CARS), or Autism Diagnostic Observation Schedule (ADOS), indicate a diagnosis of an Autism Spectrum Disorder.

☐ **Medical History and Most Recent Physical Examination:** This can usually be obtained from your primary care physician upon request. If there are psychiatric evaluations, these should be included. If the applicant has been diagnosed with Prader-Willi Syndrome, please include a copy of the physician's report diagnosing this disorder. *<u>It is not necessary to send routine medical visit information.</u>*

☐ **HIPAA Acknowledgement Form:** The form must be complete and signed by the applicant if the applicant is 18 years of age or older, or the applicant's legal guardian if the applicant is 18 years or older and has a court appointed legal guardian.

☐ **Guardianship or Conservatorship Forms:** Provide a Probate Court decree of appointment of guardianship or conservatorship if applicable. If appointed from out of state, Probate Court decree in the state of CT must be provided; otherwise applicant (Age 18+) must sign application and HIPAA acknowledgement letter.

☐ **Proof of CT Residence:** This can include the <u>applicant's</u> CT driver's license or CT non-driver photo ID, DSS Connect Card, tax form, etc.

☐ **Copy of the following:** Birth Certificate, Social Security Card (if applicable), Health Insurance Card AND Medicaid Card (if applicable). For the Early Childhood Autism Waiver, services will not be provided without the Husky A or B card.

☐ **Educational Information:** Include the last 3 years of educational records including Individual Educational Plans (IEPs), standardized test scores, and triennial evaluations. *For applicant's under 5 years of age, please submit a copy of the current IEP (if not receiving services from the Birth-To-Three program) or Individual Family Support Plan (IFSP).*

Step 3- If you are MISSING any of the above documentation, you will need to complete a **Release of Information** form and SEND it to your doctor, psychologist, school or clinic and request these records. **Do <u>NOT</u> send the release forms to DDS because DDS CANNOT send these documents for you**.

Send correspondence via:

Postal mail: **DDS Eligibility Unit, 460 Capitol Avenue, Hartford, CT 06106**
Fax: **(860) 622-2797**
Email: **<u>DDS.Eligibility@ct.gov</u>**

STATE OF CONNECTICUT
Department of Developmental Services
Eligibility Application
Page 1 of 2

Which services are you applying for? **1)** Intellectual Disability **2)** Autism Spectrum Services Division **3)** Early Childhood Autism Waiver
(Please select all that apply)

Applicant

First, Middle, & Last Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City, State, & Zip: _____ Fax: _____

Date of Birth: _____ Male or Female _____ E-mail address: _____

Social Security Number: ___-___-____ Medicaid Number: _____ Private Insurance: Yes or No
(Attach copy of Medicaid card)

Optional: Race _____ Ethnicity _____ Primary Language _____

Person Requesting Services (Referral Source with relationship to Applicant)

First, Middle, & Last Name: _____ Home Phone: _____

Address: _____ Best Contact Phone: _____

City, State, & Zip: _____ Fax: _____

Organization/Relationship (if applicable):_____ E-mail address: _____

Has Mental Retardation or Intellectual Disability been determined by evaluation? **YES** or **NO**
If 'Yes,' where and when _____

Has an Autism Spectrum Disorder been determined by evaluation? **YES** or **NO**
If 'Yes,' where and when _____

Has a Court of Probate appointed a legal guardian or conservator for this person? **YES** or **NO**
If 'Yes,' please attach a copy of the Decree, provide name of Court, and information of the appointed person:

_____

(If appointed from out of state, please provide copy of Decree from state of Connecticut; otherwise, applicant (Age 18+) must sign the application and HIPAA Acknowledgement Form).

First, Middle, & Last Name: _____ Home Phone: _____

Address: _____ Best Contact Phone: _____

City, State, & Zip: _____ Fax: _____

E-mail address: _____

Signature: _____ **Date:** _____
Signature of Applicant (Age 18+) or Legal Parent/Guardian

Please complete all information on this form and sign it
before **sending it to the Eligibility Unit.**
We will be unable to act upon your request without the necessary information.

STATE OF CONNECTICUT
Department of Developmental Services
Eligibility Application
Page 2 of 2

Please complete this section **only if** the applicant receives services from **DMHAS** (Department of Mental Health and Addiction Services).

Name of DMHAS Social/Case Worker _____ Phone Number _____

Please complete this section **only if** the applicant receives services from **DCF** (Department of Children and Families). Please provide a copy of the adjudicatory/dispositional order and note the legal status with DCF below:

_____ Voluntary
_____ Committed
_____ Juvenile Justice Commitment
_____ Family with Service Needs
_____ Case still with Investigations
_____ Other: _____

Name of DCF Social Worker _____ Phone Number _____

If Someone Assists You with This Application

Please complete the information below if someone other than the applicant or guardian is helping with the application. The person you choose to assist you may be a family member, friend, teacher, counselor, social worker, etc.

_____ _____ _____
Signature of Person Completing Form **Title** **Date**

Name (please print) _____
Relationship to Applicant _____
Agency _____
Phone Number _____

I give permission to DDS to discuss my application and records with the person named above for the purpose of completing the eligibility determination process.

_____ _____
Signature of Applicant (Age 18+)/Parent-Guardian if under Age 18 **Date**

Eligibility Fact Sheet

Intellectual Disability/Mental Retardation

In order to be eligible for supports or services from the Department of Developmental Services (DDS), a person must:

1. Be a resident of the State of Connecticut and
2. Have Intellectual Disability/Mental Retardation as defined in Connecticut General Statute §1-1g (see below)
   OR
   Have a diagnosis of an Autism Spectrum Disorder
   OR
   Provide a medical diagnosis of Prader-Willi Syndrome (PWS), which is a neurobehavioral genetic disorder that must be diagnosed by a physician.

Intellectual Disability/Mental Retardation

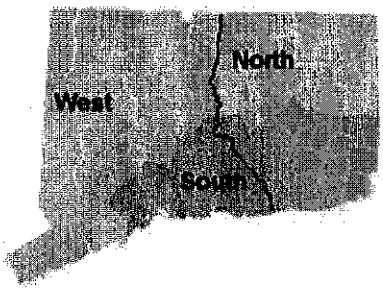
Definition Per Connecticut General Statutes §1-1g, mental retardation also known as intellectual disability, is defined as: Subsection (a) "mental retardation" means a significant limitation in intellectual functioning and deficits in adaptive behavior that originated during the developmental period before eighteen years of age."	**What Does This Mean?** A person has an IQ score of 69 or below as indicated on intelligence/cognitive tests and significant limitations in adaptive functioning, and this began during the developmental period from birth to 17 years of age.
What tests do I need? To show that an individual has Intellectual Disability/Mental Retardation, you will need to submit a copy of all intelligence/cognitive tests and tests of adaptive functioning. Scores on intelligence/cognitive tests need to be 69 points or lower. Significant limitations in intelligence and adaptive skills must be present at the same time and have existed before the individual was 18 years of age.	**Where can I get tested and who can test me?** You can get tested for intellectual disability/mental retardation at a clinic, hospital, or school (if you are under 21.) The evaluator should have a specialty in the age range of the individual and have training, experience, and a competency in diagnosing intellectual disability/mental retardation. This might include a psychiatrist, psychologist, neurologist, developmental pediatrician, certified school psychologist, or any other appropriately trained professional with expertise in this area.

What If I Am Found Ineligible?

If a decision of ineligibility is made, the reasons for this decision will be explained in the notification letter. Also included will be a form for you to submit to request a hearing on the finding of ineligibility. You may submit this form within 60 days of receiving the eligibility determination.

What Happens If I Am Determined Eligible?

Once eligibility is determined, a DDS Region (see map below) will be assigned to help you access services and supports. However, eligibility for services does not assure that requests for services can be met immediately. Services of the Department of Developmental Services are provided on a priority basis and within available appropriations.



DDS
STATE OF CONNECTICUT
DEPARTMENT OF DEVELOPMENTAL SERVICES

460 Capitol Avenue, Hartford, Connecticut 06106 ◆ Phone: 860/418-6000 ◆ Fax: 860/622-6001 ◆ Email: ddsct.co@ct.gov

November 2007

Individual and Family Fact Sheet –
HIPAA: Health Insurance Portability Accountability Act of 1996

Did you know that DDS now follows the federally mandated HIPAA regulations?

What Is HIPAA?

The federal government has established privacy laws/standards for healthcare information for all citizens. These standards are part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and provide the first comprehensive federal protection of the privacy of "health information.*"

Is Protecting My Health Information New?

DDS has always maintained good privacy and confidentiality practices based on State of Connecticut laws. The new federal privacy laws establish a set of standards for all states.

How Does HIPAA Affect DDS Individuals?

These laws/standards and existing state laws ensure that DDS will:

1. Make sure that any individually identifiable health information** is kept private, and
2. Give you a written notice of our legal duties and privacy policy practices with respect to your protected health information.

What Is The Notice Of Health Care Privacy Practices For Protected Health Information ?

The fact sheet of health care privacy practices for protected health information*** is available to all individuals served by the department. The notice describes the way DDS may use and disclose protected health information and explains how you can exercise your rights. The notice will help you understand how we share information about you and how you can ensure its accuracy. A more detailed explanation entitled "Notice of Privacy Practices for Protected Health Information" can be found at www..ct.gov/dds or a copy can be sent to you upon request by contacting 860-418-6000.

How Does DDS Share My Protected Health Information?

DDS and agencies currently providing services to you share your information for your support. A portion of this information is shared for payment activities or quality assessment and improvement. Unless you provide us with authorization, your protected health information will not be shared outside of DDS and agencies currently providing services to you except for the permitted or required disclosures described in the notice.

When Can My Protected Health Information Be Disclosed?

Disclosures that are not permitted or required by law will require an authorization from you.

STATE OF CONNECTICUT
Department of Developmental Services

DDS

Acknowledgement Form For HIPAA
Individual and Family Fact Sheet
HIPAA: Health Insurance Portability Accountiability Act of 1996

I have been provided an *Individual and Family Fact Sheet HIPAA: Health Insurance Portability Accountiability Act of 1996* that describes how information is used by the Department to provide services. This notice also includes a description of my rights regarding protected health information.

I understand DDS reserves the right to change their practices and notice. Prior to implementation of these changes a new notice will be available to me.

I understand I may be requested to sign specific *authorization* for uses and disclosures of my health information, which are not addressed in the notice.

Formulario de Reconocimiento
HIPAA individual y la Hoja de familia: Ley de Seguro de Salud de Portabilidad Accountiability de 1996

Se me ha brindado una *HIPAA individual y la Hoja de familia: Ley de Seguro de Salud de Portabilidad Accountiability de 1996,* que describe cómo usa la información el Departamento para brindar servicios. Esta notificación incluye también una descripción de mis derechos con relación a la información protegida sobre la salud.

Entiendo que el DDS se reserva el derecho a cambiar sus prácticas y notificación, y que antes de la implementación de estos cambios tendré a mi disposición una nueva notificación.

Entiendo que se me podrá pedir que firme una *autorización* específica para los usos y divulgaciones de la información sobre mi salud, que no se tratan en la notificación.

_____ _____

Signature of Individual or Legal Representative
Firma de la persona o representante legal

Date
Fecha

Effective Date of Notice: April 14, 2003 [Día de vigencia de la notificación: 14 de abril de 2003]

---

* Please explain relationship to individual/* Por favor explique su relación con la persona

_____

_____

State of Connecticut

Department of Developmental Services

Authorization for Release of Information

DDS Cannot Send This Form For You, You Must Do It.
Fill Out This Form Completely. DO NOT SEND THIS FORM BACK TO DDS.
YOU MUST Send To Each Doctor, Agency, School, etc. from whom you are requesting records.
They Will Send Information To DDS.

Applicant Information

Last Name _____ First Name _____ MI _____

Street Address _____

City _____ State _____ Zip _____

Home Telephone _____ Date of Birth _____

Organization (Agency or business holding the requested information)

Organization Name _____

Contact Person or Title _____

Street Address _____

City _____ State _____ Zip _____

Telephone _____ E-Mail _____

Information Requested (Check all boxes that apply before signing this authorization.)
To determine the applicant's eligibility, information the organization has for all dates of service is needed.

❑ School Records:	**Last 3 years of educational records including Individual Educational plans (IEPs), standardized IQ test scores, and triennial evaluations.**
❑ Medical Records:	**Most recent physical and any medical or psychiatric reports that provide information about intellectual and adaptive functioning during the developmental period (birth through 17). It is not necessary to send routine medical visit information.**
❑ Psychological Records:	**Psychological reports with IQ and adaptive test scores.**
❑ Vocational Records	
❑ Developmental Records	
❑ Psychiatric Records	

I understand this permission will expire when the information requested has been released to DDS or one year from the signature date. I understand that I may revoke this authorization at any time. I understand that any action taken on this authorization prior to the rescinded date is legal and binding. Instructions to cancel this authorization are included in the named organization's Notice of Healthcare Privacy Practices. I also understand I can request a copy of the Notice of Healthcare Privacy Practices from the named organization at any time. I understand that if my information is protected by the Federal Substance Abuse Confidentiality Regulations or State of Connecticut law regarding HIV infection, AIDS or AIDS-related conditions, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law. I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I further understand that I may request a copy of this signed authorization.

* I understand the confidentiality of psychological or psychiatric records is required under chapter 899 of the Connecticut General Statues. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statues.

_____ _____ _____

Signature of Applicant or Parent/Guardian * Print Name of Applicant or Parent/Guardian Date

* Relationship to applicant _____

In order to determine the applicant's eligibility to receive services from the State of Connecticut Department of Developmental Services (DDS), I authorize the organization named to disclose the information requested below to: ⟹

Department of Developmental Services
Eligibility Unit
460 Capitol Avenue
Hartford, CT. 06106
Fax: (860) 622-2797 Toll Free (866) 433-8192